Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PRC HEALTH SERVICES, LLC
6660 AIRLINE DRIVE
HOUSTON TX 77076

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-4297-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated June 3, 2010: "Our facility has billed these services w/the CORRECT DX of 847.1 accordingly. In addition, this DX is exactly what was accepted @ the CCH on 6/10/09. Secondly, the carrier did NOT respond to the RFR."

Requestor's Supplemental Position Summary dated August 25, 2010: "A CCH determination dated 6/10/09 (copy attached), determined that the patient did suffer a thoracic injury. This MDR case has multiple issues involving it." "The first issue is that our facility requested pre-authorization for these services on may 8, 2009 for the injury of the thoracic and lumbar regions (copy attached). In addition, the preauthorization letter (copy attached) doesn't specify a certain area of injury because the Chronic Pain Management Program is an overall program; it doesn't pertain to one specific type/area of injury." "Secondly, our facility has initially billed these services with a thoracic diagnosis code of 847.1; therefore, these services are to be reimbursed promptly. Your facility for some reason initially processed these medical bills with the diagnosis codes of 847.1, 847.2 and 724.4 and that is not the way that they were billed."

Amount in Dispute: $1,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated June 28, 2010: "This case involves DOS 06/22/09, 06/29/09 and 07/01/09 and has $1,500.00 in dispute according to the Requestor, although they admit that total MAR is $300.00. The matter was finally adjudicated. A 06/10/09 CCH determined that the compensable injury was *not* to pre-existing cervical and lumbar conditions, but to the thoracic spine area, and that disability ended on 07/28/08, implying resolution of the soft tissue injury. Preauthorization for these services was based on a lumbar injury, not a thoracic injury and thus does not indicate that such treatment was reasonable and necessary for the compensable injury.

Respondent's Supplemental Position Summary dated July 7, 2010: "Carrier maintains its position as outlined in the original response."

Response Submitted by: Flahive, Ogden & Latson, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2009 June 29, 2009 July 1, 2009	Chronic Pain Management – CPT code 97799-CP (5 hours per day X 3 days = 15 hours)	$500.00/day X 3 = $1500.00	$1500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204. Medical Fee Guideline for Workers' Compensation Specific Services. *March 1, 2008, 33 TexReg 626*, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits July 22, 2009
   - 851-Payment disallowed. Entitlement to benefits not finally adjudicated.
   - W11-Entitlement to benefits. Not finally adjudicated.

   Explanation of benefits July 23, 2009
   - 851-Payment disallowed. Entitlement to benefits not finally adjudicated.
   - W11-Entitlement to benefits. Not finally adjudicated.

Issues

1. Does an entitlement to benefits issue exist in this dispute?
2. Did the requestor support disputed treatment was preauthorized for compensable injury?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the disputed services based upon reason codes "851-Payment disallowed. Entitlement to benefits not finally adjudicated"; and "W11-Entitlement to benefits. Not finally adjudicated."

   The June 10, 2009 Contested Case Hearing found that the claimant sustained a compensable thoracic injury on June 11, 2007.

   On August 17, 2010, the Division contacted the adjuster Renne Marquez who verified that the entitlement issue has been resolved. Therefore, the disputed services will be reviewed in accordance with applicable Division rules and guidelines.

2. On May 8, 2009, the requestor sought preauthorization for twenty (20) sessions of Chronic Pain management for treatment of the thoracic and lumbar regions.

   On May 14, 2009 the requestor obtained preauthorization approval for 10 sessions of Chronic Pain Management Program between May 12, 2009 and July 16, 2009.

   Therefore, the requestor has supported position that the disputed chronic pain management rendered from June 22, 2009 through July 1, 2009 was preauthorized in accordance with 28 Texas Administrative Code §134.600.

3. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

Therefore, the MAR for a non-CARF Chronic Pain Management Program is $100.00 per hour. Based upon the Table of Disputed Services the requestor listed three (3) dates of service from June 22, 2009 through July 1, 2009. The requestor billed for five (5) hours per date, for a total of 15 hours. Using the above formula the requestor was due $1500.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	4/13/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.